UNITED STATES DEPARTMENT OF AGRICULTURE

FARM SECURITY ADMINISTRATION

REGION I

MEDICAL CARE MANUAL

January, 1941

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INTRODUCTION

This Medical Care Manual is intended to serve as a guide for the use of District RR and HM Supervisors and County RR and HM Supervisors in the development of medical care plans in Region I and in the assumption of responsibility for their successful operation.

In each area in which such plans are to be developed, it is expected that a conference of the District and County personnel and the Cooperative Specialist or Health Specialist, or both, will precede negotiations with professional groups. However, after this conference has determined the steps to be taken in the development of the plan, the final responsibility for carrying the plan through to completion will depend in a large measure upon the County personnel, and further responsibility for seeing that the County personnel complete the task will rest on the District and State personnel. The latter may avail themselves of such technical assistance from the Health Specialist as may be needed from time to time by requesting such aid through the Regional Office.

The Cooperative Specialists should be fully informed concerning all aspects of the medical care work in their areas. Their assistance should be called upon particularly in developing organizational patterns and techniques in selected counties, for example, in the first county or area in which a plan is developed in a district under the jurisdiction of a District RR Supervisor. However, the ultimate responsibility for putting a plan into operation and for insuring its successful functioning rests with the District and County RR personnel.

FUNDAMENTALS OF HEALTH PROGRAM

The general health program of the Farm Security Administration is being developed on a broad basis. Its major factors include emphasis on nutrition, adequate housing, environmental sanitation, and the full use of local public health facilities, as well as the establishment of suitable arrangements for the provision of medical and dental care. The scope of this Medical Care Manual is confined to a presentation of the fundamentals of the medical and dental care program, and a discussion of the techniques to be used in organizing this program.

The term "medical care program" may be used in the broad sense to include dental as well as medical care. The program divides itself logically into the following phases, any or all of which may be included in a plan developed in a county or district:

General practitioner care (family physician)
Surgical care
Other specialist care (example: eye, ear, nose, and throat)
Hospitalization
Provision of necessary drugs
Dental care

Because of the limited ability of borrower families to pay for medical care, the emphasis has necessarily been on providing primarily the care essential to the treatment of acute illness; but in so far as possible, provision has also been made for the correction of chronic defects which constitute a retarding factor in rehabilitation. The emphasis in any dental care plan of limited scope has been on the relief of pain and the eradication of infection which may have a direct bearing on general health. When more complete dental care plans have been possible, there has been provision not only for extractions and the treatment of infection, but preventive work for children has been stressed and provision has been made for fillings and minimum essential restorative dentistry.

The majority of early medical care plans organized in Region I were confined to general practitioner care, but certain plans did include hospitalization and surgical care. In developing new plans, the emphasis should be placed on organizing as comprehensive plans as possible. It is expected that hospitalization and surgical care will be added to most of the existing general practitioner care plans with surveys of the current experience of participating families serving as the basis for such expansion. Although no dental care plans were operating in Region I at the date of publication of this Manual, several had been operating in other Regions, and negotiations had begun with the dental profession to the end that a pattern might be developed which might be applied in the northeastern states.

The basic principles upon which the medical care plans are founded include close cooperation with state and county medical societies, dental societies, and professional groups representing hospitals and druggists; free choice of physician, dentist, hospital and druggist; basing family participation rates upon the average incomes of borrower families in the area as revealed by farm and home plans; the payment of participation dues in advance on an annual basis, and assistance to borrower families in making such payments, ordinarily through loans. The funds for participation deposited by each family are placed in a pooled or common fund in the hands of a bonded trustee, who cannot be an employee of the FSA and who ordinarily is neither a physician nor a client, but rather someone familiar with handling funds such as a bank cashier in the town in which the County Office is located. An alternative to the trusteeship form of organization is the unincorporated health association composed of client members. In such associations, which have been organized in certain Regions, there is often a treasurer instead of a trustee.

Under the arrangement usually followed, annual funds, after deduction of a small amount to cover administrative expenses, are divided into twelve monthly allotments from which bills are paid by the trustee, being paid in full when possible or on a pro rata basis when funds are insufficient to pay bills in full. (See Exhibit A, Typical Medical Care Plan.)

DEVELOPMENT OF A TYPICAL MEDICAL CARE PLAN

I - Basic Agreement with State Medical Association

The policy of the Farm Security Administration is to develop no medical care plans in a State until a basic agreement or understanding has been reached with the State Medical Association. Negotiations with the State Medical Association are the responsibility of the Chief Medical Officer or a representative whom he may designate. The State Director ordinarily participates in these negotiations.

II - Selection of County

The State Director should determine, after consultation with State, District and County personnel, the county or counties in which it is desirable to develop medical care plans in any fiscal year. Factors to be considered in selecting such counties include the demonstrable needs of the borrower families and their interest in a plan, the case load, the rural character of the county, and the existence of similar medical care plans in adjacent or nearby counties.

III - Health Survey

A health survey revealing the medical care experience of borrowers, from the point of view of charges incurred and family expenditures for various services, has been very useful in demonstrating to professional groups the need for developing medical care plans on a group basis. Such a survey made through the use of a questionnaire should be conducted in each designated county. The survey can be of value only if a high percentage of returned questionnaires is secured. Mimeographed survey forms will be forwarded by the State Office to the County Office. Completed questionnaires should be assembled by the State Office and forwarded to the Regional Office for analysis.

IV - County Office Conference

As soon as the survey analysis is available, a conference of District and County personnel attended by the Cooperative Specialist or the Health Specialist, or both, should be held at the County Office to determine ways and means of developing a medical care plan in that County. Consideration should be given to the type of plan to be established, whether limited or comprehensive in scope, the method of approach to professional groups and borrower families, and the assignment of responsibilities for activating the program.

V - Responsibilities of FSA Personnel in Developing Program

A - The Health Specialist is responsible for familiarizing District and County personnel with methods of approaching professional groups and borrower families. He also assists in making first approaches to key persons in the professional groups, and he attends, when possible, professional committee or society meetings at which decisions concerning the program are taken.

B - The County RR and HM Supervisors are responsible for continued efforts to secure the full cooperation of professional groups, and for educational efforts on a group or individual basis to inform and enroll borrower families in the plan.

C - The District RR and HM Supervisors are responsible for seeing that assigned responsibilities are carried out by County personnel. They report to the State Director on the progress of negotiations with professional groups and the progress being made in enrolling borrower families in the plan.

D - The Cooperative Specialist assists in organizational work in selected counties, particularly in the first county or area in which a plan is developed in an RR District.

VI - Suggested Approach to Physicians

A - Securing Approval of County Medical Society:

1 - In the County Office conference, a suitable approach to the local physicians should be agreed upon. In general the procedure is to enlist the interest of certain key physicians in the County, including the President and Secretary of the County Medical Society. The purpose underlying preliminary negotiations is to secure the selection of a Committee by the County Medical Society with which representatives of the FSA may work in formulating a medical care plan. As a rule a meeting of the County Medical Society must be held to select such a Committee. It is important that the FSA be represented at the meeting by one or both of the County Supervisors and by someone thoroughly familiar with all phases of the medical care program such as the Health Specialist or the Cooperative Specialist. After presentation of the problem by such representatives, it is wise to request no decision by the Medical Society other than that of selecting a Committee to study the problem and make recommendations to the Society at the next meeting.

2 - One or both County Supervisors as well as the Health Specialist or the Cooperative Specialist should meet with the designated Committee of physicians to acquaint them with the health problems

of borrower families and the plans devised by other medical societies to meet these problems. In one or more joint meetings of this type, a plan should be formulated which the Committee is prepared to recommend to the County Medical Society for approval. Whether the plan is limited or comprehensive in scope, the rates to be paid by the clients should not be in excess of the average ability of the families to pay.

3 - It has been found helpful to have copies of the recommended plan distributed to all practicing physicians in the county by the Secretary of the County Medical Society prior to the meeting at which action is to be taken by the Society. During this intervening period, both County Supervisors should continue their efforts to acquaint physicians with the rehabilitation program and the proposed medical care plan, particularly those physicians known to be serving borrower families.

4 - It is important to secure an invitation from the County Medical Society for representatives of the FSA to attend the meeting at which final action is to be taken on the proposed plan. Only in this way can there be assurance that adequate answers will be given if questions or criticisms concerning the FSA program are raised. As a rule, not more than three FSA representatives should attend such a meeting, to avoid the appearance of putting pressure on the Society. If possible, the Health Specialist or Cooperative Specialist should attend, for familiarity with plans functioning elsewhere is essential.

B - Points to Emphasize in Discussing Plan with Physicians:

In approaching the physicians, either individually or in committee of medical society meetings, it is proper to make use of any or all of the following points or lines of reasoning:

1 - In securing the approval of the physicians, it is of basic importance that they have a thorough understanding of the rehabilitation program - its aims, its different phases, the type of family eligible, the criteria for eligibility, and farm and home planning. (See Exhibit G, "Major Factors in the Rehabilitation of Farm Families".)

2 - The FSA is not placing undue emphasis on medical care as such, but it approaches the health problems of borrower families on a broad basis, including the improvement of economic circumstances of the families, which is basic, and nutrition work, adequate housing, environmental sanitation, full use of public health facilities and health education, as well as being concerned with medical and dental care, hospitalization, and the provision of drugs. (See Exhibit H, "Major Factors of the Health Program in the Rehabilitation of Farm Families".)

3 - In developing medical care plans, the approach is always through the organized medical profession. At the date of this Manual, basic agreements or understandings existed between the FSA and 39 State Medical Associations, and medical care plans adopted by County Medical Societies included approximately 90,000 families in over 700 counties in 33 States. Medical care plans include borrower families only except in the few instances where the County Medical Societies desire that certain other low-income farm families be allowed to take part.

4 - These plans do not infringe on the private practice of medicine. There is always free choice of physician. Participation is voluntary on the part of both clients and physicians. There are no contracts or binding agreements and a physician is as free as in his ordinary practice to accept or reject a case. All medical aspects of the plan are under the control of the County Medical Society. The only difference between these plans and private practice is that the physician submits his bills to the trustee of the medical care fund instead of to the families. There is no interference with the personal relationship between physician and patient.

5 - These medical care plans, although sponsored by the FSA on behalf of its borrower families, may be classed with the numerous medical society plans being developed for wage-earning groups by both State and County Medical Societies in States including New York, Pennsylvania, New Jersey, Michigan, Utah Washington and California. The basic control of these FSA plans rests with the Medical Societies, and the functioning and continuation of the plans are contingent upon the satisfaction of the Medical Societies with their operation. In fact, a plan can function in a satisfactory manner only if there is close professional supervision by the Medical Society.

6 - The plan is a local county or district plan. The only three parties directly concerned with the plan are the physicians, the families, and a trustee approved by the Medical Society. The role of the FSA is limited strictly to sponsorship, assistance with financing, and control of possible abuses on the part of participating families. The FSA is in a position to inform the physicians concerning the average ability of the families to pay for medical care, but it never sets the fees which the physicians are to charge and it never interferes with professional matters related to the plan.

7 - Long-range planning requires budgeting with maximum provision to meet contingencies. Budgeting for medical care on an individual family basis has proved ineffective because of the unpredictable character of serious illness. On the other hand,

budgeting on a group basis offers a solution of the problem by spreading the cost of necessary medical care so that it falls on the whole group of participating families.

8 - Through group budgeting and use of the "insurance" principle, all of the families are paying into the medical care fund all they can reasonably be expected to pay for the services provided, thus increasing the total revenues of the physicians who otherwise would receive payment only from the families with sickness. Moreover, the physicians are paid each month for their services, thus eliminating the problem of slow and uncertain collections from this low-income group.

9 - Under plans operating in Region I during 1939 and 1940, physicians received from 65% to 100% payment on bills rendered for medical services, and in the majority of the plans the payment was well above 75%. Health surveys conducted among the same families prior to the development of medical care plans indicated that they had paid their physicians between 41% and 64% of bills rendered, and the average was less than 52%.

10 - Although many borrower families are on the borderline of relief and have been kept from relief rolls only through our program, they are not usually eligible for medical care under State relief or welfare plans. As a group they fall between the relief group and those able to pay for most or all of the medical care required. One must distinguish between the possession of capital goods and a family's ability to pay. Large bills encountered now by these families are paid either by selling capital goods (the effects of which may be cited), or by sacrificing minimum standards of living, or they are paid only in part or not at all. (It is helpful to discuss with a physician the status or particular problems of one or more client families whom he may know intimately.)

11 - In learning to budget and pay for the services of physicians, the families are not only developing a sense of responsibility for meeting their obligations, but they are learning, usually for the first time, to make provision in advance to meet the costs of sickness and they are becoming educated to the values of scientific medical care rather than self-medication. These habits will usually remain after the family leaves the FSA rolls.

12 - Readily available medical care in case of need is "preventive medicine" in a very real sense. Self-respecting families often neglect themselves in illness because of inability to pay.

13 - Very little difficulty has been encountered in these plans through abuse of privileges by the families, and when difficulties have arisen they have usually been easily controlled. The reasons for this include the educational work performed among the families in advance, the close supervisory relationship to the families, and the usual provision that a family may be removed from the plan for continued abuse despite warnings.

14 - From the point of view of the FSA, a healthy client with readily available medical care is a much better credit risk than a client suffering from some chronic condition or one whose planning can be completely upset by the costs of a serious illness.

15 - In setting up a medical care plan the physicians are taking an active part in solving a community problem, the rehabilitation of a disadvantaged group of farm families. Rehabilitation of this group will react to the advantage of the medical profession as well as of the whole community.

16 - No plan need be looked upon as final. The plan adopted by the Medical Society is considered to be on a basis of trial for a one year's period, at the end of which it may be modified in accordance with experience. The record indicates that whereas many plans have been revised and improved, very few have been terminated by either FSA or Medical Society action.

C - Notes of Caution in Approaching Physicians

The approach to physicians should be a positive one, along lines indicated in the above paragraphs. Be careful to avoid stating that the clients are not getting medical care at present (see an alternative approach in paragraph 12 above). Avoid any reference to "socialized" or "state medicine", terms which have no relationship to our plans (see positive statements in paragraphs 3, 4 and 5 above). Avoid the terms "cooperative medicine" or "medical cooperative", neither of which describes these plans. If the question of physicians' fees comes up, make it clear that the FSA never sets fees to be charged. If federal control is mentioned, emphasize, as in paragraphs 4, 5 and 6 above, that the plan is a local one under Medical Society supervision, without outside interference or control.

VII - Approach to Other Professional Groups

The approach to other professional groups should be guided by the same basic considerations which govern discussions with physicians. Therefore, many of the points to be emphasized in discussing the plan with

physicians are equally valid in discussions with hospital representatives, pharmaceutical and dental groups.

A - Hospitals, Hospital Associations and Hospitalization Plans

1 - Hospital care should be incorporated in medical care plans when it is possible to work out arrangements which bring this essential service within reach of the families without costing more than they can afford to pay. (For minimum basic services which should be included in any such arrangement see Exhibit A, Typical Medical Care Plan.) Occasionally it may be possible to have the Committee of the County Medical Society assume responsibility for negotiating with local hospitals to the end that a suitable hospital care plan may supplement the plan for physicians' services. On the other hand, the physicians usually insist that hospital care arrangements be developed separately by negotiation between the FSA and the hospitals concerned. In any event, it is essential to have the direct assistance of the Health Specialist or Cooperative Specialist, both of whom are familiar with such plans in other areas.

2 - Since it is always desirable to provide for free choice of hospital on the part of families, any hospital care arrangement should, if at all possible, extend to every general hospital in the area, particularly those registered by the American Medical Association. The arrangement with various hospitals in the area should be uniform so far as services and rates are concerned.

3 - Appropriate contacts with state hospital associations will often lead to the establishment of satisfactory working relationships with hospital administrators in counties in which medical care plans are being developed. The original contacts with such organizations should be left to the Chief Medical Officer or his designated representative.

4 - A considerable number of non-profit group hospitalization plans are now operating in Region I, but with very few exceptions they are not suited to the particular needs of low-income rural families. Fortunately there is a trend toward the development of ward care plans, the cost of which may come within the ability of FSA clients to pay. However, since a matter of general policy is involved, clients should not be encouraged to join any existing hospitalization plan unless the plan has been reviewed and approved by the Regional Office and the Chief Medical Officer.

5 - Surveys are constantly being conducted to reveal the actual hospitalization experience of client families in various areas in Region I. With this basic information available it is hoped that one or more state-wide hospitalization plans designed to meet the needs of FSA clients may be developed through the cooperation of state hospital associations and existing group hospitalization plans, and that such plans may provide minimum basic services at a cost within the average ability of the families to pay.

B - Druggists and State and Local Pharmaceutical Societies

1 - When conditions are favorable, medical care plans should include not only bedside and office medication but minimum essential prescribed drugs furnished by druggists on physicians' prescription. The provision of prescribed drugs may be difficult in industrial areas or any area including cities with a considerable number of drug stores, but in typically rural areas it may be possible, with or without negotiation with the State Pharmaceutical Association, to develop plans which permit group budgeting to cover the cost of essential drugs. It is desirable from the point of view of economy to limit such provision when possible to "official" drugs; that is, U. S. Pharmacopoeia and National Formulary preparations.

2 - There are various ways to finance the provision of drugs; such as setting up a special fund for the purpose, or arranging that druggists' bills will be considered preferred charges against the medical care fund within certain definite limitations. The complexity of developing suitable arrangements for the provision of drugs is such that the assistance of the Health Specialist should always be requested in cases where such supplementation of the services is desired.

C - Dentists and State and Local Dental Societies

The development of dental care plans is similar in most respects to the organization of medical care plans so far as basic principles are concerned, and the approach to dentists and state and local dental societies is analogous to the approach to the medical profession outlined above. No effort is made to deal exhaustively with this subject in this Medical Care Manual, for the development of dental care plans in Region I at the time of this writing was still in the preliminary stages. It is expected that suitable material concerning the development of such plans may later be available for distribution.

VIII - Suggested Approach to Clients

A - Securing Participation of Families

1 - Group meetings of clients, whether or not held for the special purpose of discussing health problems, offer an opportunity to build a medical care plan on the sound foundation of an informed and interested group of families. The whole idea of a medical care plan is new to the families, although some of them may be aware of the need for finding a solution to their common health problems. To be able to guide the discussion in a constructive way, the Supervisors must have general knowledge of the health and medical care problems confronting the families and specific knowledge of the provisions of the medical care plan known to be acceptable to the local physicians. If negotiations with the Medical Society have reached the point where a specific plan has been agreed upon, it will be found helpful to distribute a brief mimeographed outline of services and participation rates to families attending group meetings. (See Exhibit B, Abstract of Typical Plan for Distribution to Clients.) If the local situation is such that the exact provisions of the medical care plan have not yet been decided, the families should be given every opportunity to make their wishes known concerning phases of medical care to be included in the plan, but their suggestions must necessarily be based on full discussion of plans found practicable in other counties in the general area.

2 - A second method of informing families concerning the medical care plan is through individual contacts in the office or during farm and home visits. This method is necessary in the case of families unable to attend group meetings and also families who fail to make a definite decision concerning participation when they attend group meetings. However, the individual approach should never be substituted for group meetings as the principal method of enrolling families in medical care plans. Group meetings not only conserve the time of the Supervisors, but they have the invaluable effect of providing for group discussion of common problems.

3 - Advantage will be taken of some group meetings to approve selection of a trustee, to select an Advisory Committee of Clients, to have participation agreements signed by the families, and to prepare loan papers in connection with financing participation. Whether or not these steps will be taken will depend upon the state of development of the plan in a given area.

B - Securing a High Percentage of Enrollment

1 - "Participation on the part of a high percentage of the clients is desirable from the point of view of the clients, the physicians, and the Farm Security Administration. Not only is the soundness of the plans involved, with all that implies, but more important, the security of the individual family, the vital importance of health and readily available medical care to rehabilitation, and the protection afforded the government by reason of the fact that a healthy client is a better credit risk." (Quoted from Regional RR Field Instruction #240)

2 - Regional RR Field Instruction #240 further provides that in all counties in which medical care plans are operating or are being developed, consideration must be given to writing client participation into every farm and home plan. Where new or supplemental loans are being submitted, a request for funds to participate in the medical care plan should be included. Moreover, in cases where clients are not securing supplemental operating loans and yet do not have funds to participate in the program, provision is made for submitting supplemental loans for this particular purpose. An approach must be made to every standard client in a county to secure his participation in the program if possible, and in any case where there is a failure to participate, a note of explanation must accompany any loan papers, setting forth the reasons given by the client for failure to participate. Field Instruction #240 adds: "Lack of funds or the inability as indicated by the Farm and Home Plan to assume the added financial obligation to the detriment of other living standards should not be accepted as an excuse for failure to participate, because the mechanism is available in grant procedure to handle situations of this type."

3 - Certain families, for various reasons, do not utilize the services of doctors of medicine. Bearing in mind that participation in these plans is voluntary, no compulsion should be exerted to secure participation of such families in the plan.

4 - When good attendance at group meetings has been assured by the preparation of an effective letter and in other ways, and when the plan has been well presented by the Supervisors, little difficulty has been encountered in securing a high percentage of enrollment. The points outlined in the following paragraphs will be found helpful in discussing the plan with the families.

C - Points to Emphasize in Discussing Plan with Families

1 - A very effective argument to use with families is that the FSA program is essentially a "planning" program and that planning cannot be complete without provision to meet the costs of unexpected sickness. It is always wise to precede any outline of the medical care plan with general discussion concerning the rehabilitation program as such, leading from that to a discussion of factors which can upset farm and home planning. Such factors, for example, include weather conditions and such unforeseen occurrences as fire. (Do not fail to point out the analogy between fires and fire insurance on the one hand and sickness and "health insurance" on the other.) This will lead into a general discussion of health needs and the special problems related to the high cost of medical and hospital care in serious illness, and in this discussion pertinent findings in the health survey previously conducted will be found helpful.

2 - The burden of medical care costs falls very unequally upon any group of families because of the uneven incidence and unpredictability of most sickness. For example, one national survey indicated that families with incomes under $1200 incurred medical care costs under $10 in the case of approximately one-third of the families; costs ranged from $10 to $40 in the case of another third of the families; and from $40 up in the other third. Approximately one family in ten incurred charges of over $100 during the year. Only by applying the "insurance" principle by having all families pay a reasonable amount into an annual medical care fund can this burden of sickness costs be overcome by distributing it evenly over the whole group.

3 - It is helpful to have individual clients testify concerning the financial or other effects of serious sickness in their own families, or, when a medical care plan has been operating in the county, testify as to the direct value which they have received through active participation in the plan.

4 - Some families may argue that they have had very little sickness over a period of years. However, every responsible physician can testify to the fact that most serious sickness is unpredictable, and the heads of any such families should not lightly disregard their responsibilities when they have such an opportunity of obtaining, at reasonable cost, a high degree of security against sickness. While in a given year, the healthy families help to pay for care received by less

fortunate neighbors, sooner or later practically every family incurs serious illness and needs the help which others provide through the plan.

5 - No family should get the impression that it should try to get its money's worth each year. The chief purpose of the plan is to provide for serious sicknesses which often represent family catastrophes. The soundness and success of the plan depend on the fair play of all participating families.

6 - The prepayment basis of these plans means that every family is entitled to medical care in case of need and insures medical attention early in sickness, thus constituting "preventive medicine" in the best sense. Through the operation of the plan the financial barrier which has often kept patients from their physicians has been removed.

7 - The families should understand that the physicians are not "profiting" unduly from the plan. It is only right that physicians should receive a reasonable return for their services. The education of physicians is long and costly, and they are put to constant expense to maintain suitable equipment and to purchase necessary drugs and supplies. They cannot be expected to continue to serve families on the basis of promises to pay. In cooperating in the medical care plan the physicians are making certain definite concessions in return for the certainty of reasonable and prompt payment for their services. Families participating in the plan are entitled, as a group, to more medical service than they could purchase with the same amount of money if there were no plan.

8 - The families have a definite responsibility for the success of the medical care plan. They should not only seek to control possible abuses which might endanger the plan but should take an active interest in its operation and be prepared to make recommendations concerning any desirable modification in its provisions. As soon as practicable there should be an Advisory Committee of Clients charged with certain special responsibilities toward the operation of the plan.

9 - A useful approach in enrolling the families in the plan is to place the whole emphasis on <u>how</u> to participate rather than on <u>whether</u> to take part or not. Thus the emphasis can be thrown to a discussion of alternative methods of payment, for example, whether by cash or through loans. This point is brought out to emphasize that the successful enrollment of a high percentage of families depends to a large extent upon the general attitude of the Supervisors in presenting the plan.

IX - Methods of Financing Participation

All medical care plans must be set up to conform to general FSA policies and procedures.

A - When developing the farm and home management plans with client families (whether or not they are already standard RR clients or new applicants), in any county in which a medical care plan is being developed, provision should be made for participation in the medical care plan. Include sufficient funds for this item in Table 4 of Form FSA-RR 14a. Provision should be made to secure this amount in any of the following ways: from a cash payment; as part of the rehabilitation loan, if a new applicant; as a release of chattel goods, or as a supplemental loan if already a standard borrower; and, in exceptional cases (whether a new applicant or a standard borrower) by the use of grants.

1 - The usual method of financing participation is to include a request for medical care participation funds as an item on the loan request (FSA-RR 15) when making either new or supplemental loans for any purpose.

2 - If there is a cash payment, it is suggested that provision be made with the participating family to have this payment available well in advance of the starting date of the plan, either in the supervised bank account, or by check or money order made payable to the trustee of the medical care plan.

3 - If a release is given in the case of a standard rehabilitation client to provide funds for participation, it is suggested that provision be made, as above, to have this payment well in advance of the starting date of the plan.

4 - When supplemental loans for medical care only are made, they should conform to Section 7 below, as regards security.

5 - The use of grants for participation in the medical care plan, either for new applicants or standard RR borrowers, is outlined in detail in FSA Instruction 741.1, IV 3. Grants should only be considered when it has been demonstrated that the borrowers' resources will not provide funds for meeting the expense of such medical service during the period for which membership in the medical care plan is effective.

6 - Vouchers for loans or grants may be prepared with subsequent payment date, which should be set at least two weeks in advance of the starting date of the plan.

7 - Security. In cases where a loan application is for medical care only, no new mortgage is necessary at the time of delivery of the check if the future advance clause in the existing mortgage secures this advance. However, the note must be described in the next mortgage taken.

B - Policies concerning enrollment during the fiscal year of a plan may differ, but a sound policy is to permit participation on a proportionate payment basis (that is, paying in accordance with the number of months remaining in the fiscal year of the plan) except when less than six months remain, in which case it is advisable to provide for participation in the plan for this period and, in addition, for the following twelve months' operating period. In any case, it is essential that the participating family should be assured for uninterrupted medical service during the period for which the farm and home plan has been written.

X - Participation Agreement

A - The participation agreement is an agreement between client and trustee which provides for deposit of participation funds by the client in a medical care fund administered by the trustee on behalf of the clients as a group. (See Exhibit C, Participation Agreement.) The participation agreement is signed by the client at the time of enrollment in the plan and signed by the trustee when participation funds are deposited in his care. Two extra copies of the participation agreement are prepared at the County Office, the names of client and trustee being typewritten. The original is retained by the client; one copy is submitted to the Regional Office for file with the client's docket; and one copy is retained in the County Office.

B - The participation agreement should be drawn up in accordance with the attached form which has been approved as to legal sufficiency, except that certain provisions peculiar to a given plan may make it necessary to have this agreement revised, in which case it should be checked by the Regional Attorney.

C - The participation agreement mentions, in paragraph 3, an "attached Abstract" of the medical care plan. (See Exhibit B, Abstract of Typical Plan for Distribution to Clients.) Such an abstract outlining services, rates and other information essential to the clients, should be prepared, mimeographed, and attached to each participation agreement.

D - The preparation of the participation agreement and the abstract of the plan for the clients is the responsibility of the Health Specialist, who should call upon the Regional Attorney for such assistance as he may need regarding legal sufficiency.

E - The participation agreement and the abstract of the plan, when approved by the Health Specialist, should be mimeographed at the State Office for use in the County where the medical care plan is being developed.

XI - Identification Card

A - Upon payment of his annual dues, each participating client should have issued to him by the trustee, prior to the starting date of the medical care plan, an identification card. (See Exhibit D.)

B - Every participating client should receive a new identification card immediately prior to the starting or renewal date of each fiscal year of the plan. A client enrolling in the plan after the starting or renewal date should receive an identification card indicating that he is entitled to services from the date of deposit of his dues until the end of the fiscal year of the plan, even though dues may have been paid for the next year's participation as well. At the beginning of the new plan year he should receive a new identification card.

C - Identification cards should be numbered so as to correspond with the family number used in the accounting system set up by the trustee. On the back of each identification card should be listed the names and ages of those members of the client's family eligible to participate in the plan.

D - In some Regions the identification card has been signed on the back by the physician serving the family, with the thought that he would continue to serve the family except for emergencies when he might not be available or until such time as the family might desire to select a new family physician. This device has been used to control "shopping around" among physicians.

XII - Advisory Committee of Clients

A - During the enrollment of the families, either at group meetings or through individual conferences, the County RR and HM Supervisors should arrange for the selection and approval of three or five client representatives as an Advisory Committee. If possible the Committee members should be elected, but it is

recognized that the first year it may be necessary to select the members or to combine both election and selection to secure a Committee representative of clients throughout the county.

B - The Committee should be given an opportunity to concur in the selection of a trustee for the medical care plan, who must also be approved by the professional groups and the County Supervisors.

C - The Committee should review, with the County RR and HM Supervisors, all complaints from the Medical Review Committee concerning abuses on the part of the client families, so as to determine ways and means of handling such cases.

D - The Committee should also be given an opportunity to take an active interest in all phases of the general health program including nutrition, environmental sanitation and public health activities in addition to the medical care plan.

XIII - Trustee: Selection, Bonding and Duties

A - The Trustee should be a person qualified to handle funds, who is not a member of one of the three interested groups (physicians, clients or FSA personnel). The usual custom is for the County RR Supervisor to select tentatively two or more persons whom he believes to be conscientious and probably interested in the work, and to propose their names both to the Medical Review Committee and the Advisory Committee of Clients, securing the approval of both groups for the person finally designated.

B - The Trustee must be bonded. (See FSA Instruction 734.1, II K 1-7.) The cost of this bond should be paid from administrative funds of the medical care plan. As a general rule the amount of the bond should be determined by the total amount of the pooled fund at the beginning of the plan's operations. The bond should be executed as promptly as practicable by the Trustee after he is selected, and should be in force before any monies are turned over to him.

1 - The bond form (FSA-LE 251) should be executed and distributed as follows: (a) Two original signed copies, one for the bonding company and one for the Regional Office; (b) two typed copies of the original, one for the County file and one for the Regional Office.

2 - As soon as the bond is issued, forward promptly to the Regional Office one original and one copy, together with evidence of payment of annual premium.

C - The Trustee should receive and receipt for funds of client families to be deposited for medical care (using pre-numbered, duplicate receipt books), and should issue checks promptly against said funds in payment of services rendered to the families eligible under the plan after itemized bills have been rendered by attending physicians and approved by the Medical Review Committee. Such disbursement of funds should be in accordance with the provisions of the medical care plan as it has been approved by the professional groups and representatives of the FSA. The Trustee's responsibility for preparing monthly reports is outlined below. (See XVI below.)

D - The Trustee receives some compensation for his services. Funds for administrative expenses are deducted from total funds available in an amount which ordinarily does not exceed 5% of total funds (or $1.00 per family if dues exceed $20.). The Trustee uses administrative expense funds to pay the cost of bonding, to purchase ledgers, bill forms, identification cards, postage, and stationery. He retains any balance in the administrative expense fund as reimbursement for his services.

XIV - Medical Review Committee

A - The County Medical Society, simultaneously with approval of a medical care plan, should authorize the president to appoint a committee, as provided in the plan, to act as a Medical Review Committee. Frequently this duty is taken over for the first year by the special Committee which formulated the plan in collaboration with FSA representatives.

B - The Medical Review Committee should meet regularly and promptly each month to review all itemized bills rendered by physicians for services to participating families and, subject to any action they may take on such bills, should then submit them promptly to the Trustee for payment. In some plans the participating physicians submit bills directly to the Chairman of the Medical Review Committee, whereas in other plans the bills are sent first to the Trustee who assembles and transmits them to the Chairman of the Committee. In no case should the Trustee assume the responsibilities of the Medical Review Committee. The Committee's action on all bills is final.

C - The Medical Review Committee should review all hospital bills rendered to the Trustee if provision is made in the plan for such review with the approval of both professional groups concerned.

D - When possible the County RR or HM Supervisor should arrange to meet with the Medical Review Committee as a means of promoting a close working relationship and avoiding unnecessary misunderstandings.

XV - Reporting Medical Care Plan on Form FSA-RR 23

This statement supplements Instruction 734.1 IX.

A - Prepare FSA-RR 23 as soon as medical care plan is organized and effective starting date is fixed.

B - Prepare five copies: one for County Office files, one for the State Office, and forward three copies to the Regional Office. (See Exhibit E, Form FSA-RR 23)

XVI - Records and Reports

A - Necessity for System of Records and Reports

Every medical care plan which is developed, should be implemented by a simple system of records and reports. These are useful locally because they reveal the volume of service each family is receiving and what doctors are participating. They also help to determine whether abuses are occurring. Ways and means of improving the plan can often result from a study of the records after the first year's operation is completed. Local professional groups and participating families, as well as District, State, Regional and Washington personnel are interested in receiving periodic reports concerning such plans in order that they may be compared with similar plans operating elsewhere.

B - Suggested System of Accounting

1 - FSA Instruction 357.1, Exhibit A, provides for a suggested system of essential records and report forms for medical care plans. While this "simplified accounting system" is recommended for use by all medical care groups, it may be modified to fit local conditions by action of the Health Specialist in consultation with the Finance Regional Manager.

2 - Help and instruction in setting up the accounting system should be furnished the Trustee by the Health Specialist or the Cooperative Specialist. It is suggested that such ledger forms as are finally adopted be mimeographed, as a matter of

economy, and be available prior to the starting date of the plan. These forms must be paid for from the portion of the fund set aside for administrative expenses.

C - Use of the Report Form FSA 204

1 - Complete instructions for preparing Form FSA 204 (Rev. 8-8-40), "Report of Health Services", are outlined on the back of the form. As provided in FSA 357.1 II, the form will be prepared by the Trustee from information which is available in the accounts. This report is submitted monthly, and also as of the close of business for each six months' period, for activities carried on from January 1 to June 30, and from July 1 to December 31 inclusive.

2 - Form FSA 204 should be prepared in an original and five copies, to be distributed as follows: the original and two copies to the Regional Director; one copy to the State Director; one copy to the County RR Supervisor; and one copy to be retained by the Trustee. Two of the three copies sent to the Regional Director are transmitted by him to the Chief Medical Officer.

3 - The County RR Supervisor is responsible for the submission of Form FSA 204 in accordance with the instructions given above. The Trustee should fill out at least one copy of Form FSA 204. The County Office may assist him by preparing the necessary additional copies for distribution as above.

D - Reports to County Medical Societies and Other Professional Groups

The information contained in Form FSA 204 may be made available to the Medical Review Committee, or other professional groups concerned, in a letter or in a simple report, but never on Form FSA 204.

E - Reports to Clients

From time to time the information contained in Form FSA 204 should be made available to the clients in group meetings or through the Advisory Committee of Clients in order that they may be informed concerning the operation of the plan.

RESPONSIBILITIES OF FARM SECURITY ADMINISTRATION PERSONNEL TOWARD AN OPERATING MEDICAL CARE PLAN

I - Responsibilities of County RR and HM Supervisors

A - Local Responsibility for Successful Operation

The various FSA specialists can give only limited technical assistance in organizing medical care plans. The responsibility for their successful operation is that of the County RR and HM Supervisors. These plans will not operate by themselves, but if they are well organized and if the Supervisors keep in close touch with their operation, they will function smoothly and greatly simplify the medical care problems otherwise faced in connection with individual families. A thorough understanding of all phases of the plan is vitally important to the Supervisors. Various materials such as the outline of the plan, correspondence with the County Medical Society, and monthly reports of the plan's operation should not be promptly consigned to the files but should be subject to careful study. County staff conferences at intervals, devoted to a review of the functioning of the plan, are highly desirable. Responsibility should be assigned to particular members of the County staff to keep in touch with certain key physicians, the Medical Review Committee, the Advisory Committee of Clients, the Trustee, and borrower families individually and in groups.

B - Useful Information to be Gained from Records

1 - Although part of the Trustee's records must be considered confidential, a study of these records, particularly the members' ledgers, will give the Supervisors useful information concerning families for whose rehabilitation they are responsible. This information may be very helpful not only as an aid to rehabilitation but as a basis for discovering and controlling abuses.

2 - Since the diagnosis of an illness is confidential information shared ordinarily only by the physician and his patient, any information concerning diagnoses revealed by the physician's bills in the records, should be used with great caution. However, it would not be exceeding the bounds of professional ethics if a Supervisor were to approach a physician with a general query such as "I understand the records show that Mrs. A

has had a great deal of illness lately. Is there anything our office can do to help her or the family?"

C - Control of Abuses

1 - The members' ledger shows the number of office and home calls received by each family. It indicates the families or individuals incurring bills every month. It also shows whether any families are "shopping around", using several physicians. Although it is the responsibility of the physicians themselves through the Medical Review Committee to bring abuses to the attention of the Supervisors, trouble may sometimes be forestalled by occasional study of the members' ledger.

2 - Many plans provide that when abuses on the part of the families are brought to the attention of the Supervisors by the physicians or by the Medical Review Committee, the Supervisors are responsible for seeing that the situation is corrected. However, a sound principle is to have such abuses handled by the Advisory Committee of Clients when possible, especially when abuses have become general enough to constitute a distinct problem. Under the latter circumstances a letter sent out to all participants, signed by the Advisory Committee of Clients, may be very effective. One responsibility of the Supervisors dealing with such abuses is to see that a family's interests are protected and that its side of the question is heard. Some plans provide that a family continuing to abuse its privileges despite repeated warnings, may be dropped from the plan, but it is wise to base such action whenever possible on the mutual agreement and consent of both the Medical Review Committee and the Advisory Committee of Clients.

D - Responsibility for Monthly Reports

Although the Trustee is responsible for preparing the monthly report on Form FSA 204, it is the responsibility of the County RR Supervisor to see that this report is prepared promptly and that the proper distribution of copies is made. The Supervisor should also make sure that the County Medical Society is receiving at least a quarterly report concerning the operations of the plan, either through the Trustee and the Medical Review Committee or through the County Office. It is not wise to give a copy of Form FSA 204 to the physicians, for it is an official governmental form which might give the impression that the plan is dominated by the FSA. A wise alternative is for the Trustee or the Supervisor to give the physicians the same information which appears on Form FSA 204 in a letter or in a simple report, made available to them at intervals.

E - Keeping District Supervisors and State Office Informed

The County RR and HM Supervisors should keep in mind their duty of informing the District Supervisors and the State Office regarding any developments of interest in connection with the medical care plan, particularly when serious difficulties of any sort arise. It is not sufficient simply to mail copies of Form FSA 204 at monthly intervals.

F - Keeping Clients Informed and Interested

1 - The County RR and Hm Supervisors should meet with the Advisory Committee of Clients at least two or three times a year. The operation of the plan can be reviewed at such meetings. Both at these conferences and in group meetings, the clients should be given an opportunity to express their ideas concerning possible modification of the plan or its expansion. Occasionally the State Office may request more specific opinions on these matters from all the clients, through the use of a survey or questionnaire form.

2 - A letter sent out to all clients by the Advisory Committee of Clients or by both Supervisors, at intervals of from two to four months, would serve a useful purpose in stimulating interest in the program.

3 - Retaining the active interest of participating families, especially those not requiring much medical care, is vitally important. Families may not continue in the plan during subsequent years unless they fully understand the basic principles underlying the plan and have an opportunity to express an active interest in the operation of the plan.

G - Enrolling New Participants in Plan

Supervisors should not be content with leaving the membership of the plan at its original level. Continuous efforts should be made to enroll both old and new clients. Paragraph IX B on page 16 outlines the methods of financing and information concerning the payment of proportionate dues for the balance of a plan's fiscal year. There is little excuse for not enrolling virtually all new clients in the plan, because it is not difficult to show them that the medical care plan is an integral part of the general rehabilitation program of the FSA and that their participation is expected.

H - Use of Grants in an Operating Medical Care Plan

1 - The proper use of grants in financing participation in a medical care plan has already been dealt with in section IX on page 15.

2 - It is proper to use medical care grants for services not included in an operating medical care plan, provided that the use of grant funds in the particular situation involved is in accordance with FSA procedure. The services in such instances must be "essential to the rehabilitation of the families", and such grants can be made only "for immediate and pressing needs" (FSA Instruction 741.1).

Example (a): A client participating in the medical care plan is hospitalized for 30 days in an acute illness, but the plan provides hospital care for only 14 days. It is proper to make a grant to cover the additional 16 days of hospital care, provided that the expense cannot be handled through the family's own resources, through a supplemental loan, or through assistance from other sources. (The rate paid to the hospital through the grant ordinarily should not exceed the rate agreed upon for the purposes of the plan.)

Example (b): A client participating in the plan urgently requires a surgical operation for hernia. The condition is known to be retarding rehabilitation. The particular plan under consideration excludes operation for hernia as treatment of a pre-existing condition. If review of the farm and home plan reveals no possibility of financing the operation by any other means, and if outside sources of assistance have been exhausted, the use of a grant may be considered. In such a case, the amount paid the hospital (and the fee paid the surgeon, if surgical care cannot be obtained without cost) should not be in excess of local welfare rates.

3 - When a client has failed to take advantage of the opportunity to participate in a medical care plan, grant assistance should not be extended to the family for any medical service included in the provisions of the plan.

4 - From the point of view of rehabilitation, it is important that subsidy in the form of a grant be thought of in terms of the farm and home plan and in terms of making up a deficiency in the annual family budget. In discussing a possible surgical operation such as in Example (b) above, with a surgeon or hospital superintendent, the discussion should center around ways

and means of paying the cost of the operation out of family income, and little or no mention should be made of the availability of grant funds. If payment over a period of time can be arranged, it is often possible to have a substantial portion of the total cost paid from family income, with the balance made up from grant funds. There is sometimes a tendency for the normal relationship between patient and physician or hospital to be disturbed when a large bill is paid in cash all at once. In such cases, the physician and hospital authorities tend to misunderstand the function of the FSA and to try to do business directly with our organization as with any other relief agency. It should always be borne in mind that supervisors cannot guarantee payment from FSA loan or grant funds.

5 - When grants are made for participation in a medical care plan, or for "immediate medical care and hospitalization", it is appropriate to have the work agreement or "Pledge of Cooperation" provide for the performance of constructive farm and home work related directly to the health of the family; for example, the improvement of sanitary facilities.

6 - Medical care grants of any type should be used with caution in any county in which a medical care plan is operating. In approving the plan, professional groups make certain concessions based largely on the fact that the families themselves are contributing to the medical care fund within their average ability to pay. When medical grant funds are used carelessly, the professional groups rapidly change their attitude for they see little reason to make concessions if payment of fees and charges in full is possible through grants.

I - Anticipating Renewal of the Plan

1 - If the original agreement with the County Medical Society extends for only a one year period, which is the usual custom, steps should be taken at least four months before the end of the plan's fiscal year to see that the County Medical Society takes the necessary action to renew the plan, preferably for an indefinite period with automatic renewal from year to year.

2 - The Supervisors are responsible for the continuous operation of the plan from one year to the next without permitting any gap in the services available to participants. This implies that the need for assisting the clients in financing their participation the second and third years must be kept in mind, and that renewal of the medical care plan must be anticipated by at least three or four months. Ordinarily the financing should be handled when current farm and home plans are being written.

II - Responsibilities of District RR and HM Supervisors

A - In line with their responsibility for all phases of the rehabilitation program in their areas, the District Supervisors are responsible for seeing that the County Supervisors carry out their duties as outlined above. When visiting counties in which medical care plans are operating, the District Supervisors should determine whether the plans are functioning in a satisfactory manner, and, if not, where difficulties have arisen. To do this intelligently, the District personnel must be thoroughly familiar with these plans, copies of which are of course available in the county offices.

B - District Supervisors should look for the opportunity to meet the Chairman of the Medical Review Committee and the Trustee, for in discussing the plan with these key persons much can be learned concerning its operation and concerning aspects of the plan which might have escaped the attention of the County Supervisors.

C - District Supervisors may find the following questions helpful, as points to raise in reviewing the operation of a medical care plan:

Are all parties living up to the provisions of the agreement embodying the plan?

What percentage of the client load is enrolled in the plan?

Are new borrowers being enrolled?

Are clients satisfied with the plan? Are they kept informed concerning its operation, and do they have an opportunity to express their opinions concerning it? Do the Supervisors meet with the Advisory Committee of Clients at intervals?

Are the physicians satisfied with the plan? Does the Medical Review Committee function effectively?

Have there been abuses of privileges on the part of the families? What persons are incurring bills every month, or are using more than one physician during the month? What steps have been taken to confirm the existence of abuses and to eliminate them? Does the Advisory Committee of Clients play a part in the control of abuses?

Are accurate records being kept? Are bills paid promptly? Are monthly reports being submitted promptly?

Is renewal of the medical care plan being anticipated, both as regards continuous client participation and renewal of the agreement by the County Medical Society?

D - The District Supervisors are responsible for keeping the State Directors informed concerning the current status of medical care plans in their areas.

E - District Supervisors should assume responsibility for requesting further technical assistance on the part of the Health Specialist or Cooperative Specialist if they find conditions which warrant such assistance.

MEDICAL CARE FOR RESETTLEMENT PROJECT AND TENANT PURCHASE CLIENTS

When there are Resettlement Project clients in counties in which medical care plans are being organized for RR clients, it is desirable to have them participate in such plans. No separate plans should be set up for Resettlement clients, for this only leads to confusion among physicians who are naturally unfamiliar with the different administrative units within the FSA.

When it is expected that Resettlement clients will take part in a plan being organized, administrative personnel charged with responsibility for the Resettlement program should be invited to participate in planning for the promotion and development of the plan. Appropriate methods of financing client participation should be utilized, as in the case of RR clients. When a considerable number of Resettlement clients take part in a given plan, they should be represented on the Advisory Committee of Clients.

Ordinarily Tenant Purchase clients are given an opportunity to participate in the medical care plans designed primarily for RR clients. Their participation should be approved by the County Medical Society, particularly in any county in which the TP clients are in a substantially higher income group than that of the RR clients in the county.

APPROACH TO HEALTH PROBLEMS IN COUNTIES WITHOUT MEDICAL CARE PLANS

Pending the development of medical care plans in an area, there is much which the County Supervisors can do to promote the physical well-being of borrower families and to solve the difficult problems related to sickness and disease.

Inherent in the rehabilitation program is emphasis on scientific nutrition, a preventive measure of the utmost importance. Alert and imaginative Supervisors are also in a position to lay stress on adequate clothing, on decent housing, on the control of dilapidation (and thus on safety in the home), and on home hygiene in general, including the proper use of a home medicine and first aid cabinet.

A disease control measure of basic importance is found in the improvement of home sanitation. Community as well as family health is involved. Through the special environmental sanitation program, through use of the "Pledge of Cooperation" when any grant is made, and through educational efforts in general, borrowers may be induced to protect their water supplies against contamination, to provide proper means for the disposal of human waste, and to screen homes against insect pests which transmit disease.

Through established health agencies, both public and private, many services are available at no cost to the borrowers. The Supervisors should make a point of becoming familiar with all such agencies which operate in their areas. They should acquaint the administrative and field personnel of these agencies with the FSA rehabilitation program, and should enlist their cooperation in extending to various borrower families appropriate services within the scope of their programs. In this way, and by educating families to use available facilities, it is often possible to accomplish effective work in the field of prevention, through immunization, well-baby, pre- and post-natal, and chest clinics or conferences. In some areas dental clinics are held for pre-school and school children, and in some there are eye clinics and arrangements for securing glasses at very low cost. The nation-wide program of aid to crippled children offers the best available orthopedic care including surgical corrections and hospitalization.

Public health nurses associated with county and state health departments are glad to visit the homes of borrowers and to extend the benefit of their knowledge of agencies dealing with various aspects of the health problem. Through their educational activities they can also supplement the efforts of HM Supervisors in promoting family health.

Through state and county welfare agencies and state aid programs, free or low cost medical and hospital care is often available not only to indigent families but to those who might be called "medical indigents", persons who cannot pay for medical care without sacrificing the necessities of life. The Supervisors can often be instrumental in securing needed medical and hospital care for client families by demonstrating their inability to finance the care themselves. In some cases free care can be secured in this way; in others, the only charge may be a low flat rate for hospital care, with no charge for physicians' services.

Grant funds should be used judiciously in counties without medical care plans. If physicians and hospital authorities become accustomed to having bills paid in full, even at welfare rates, it becomes difficult to overcome their objections to the institution of a medical care plan which is based on the average incomes of the borrowers, and through which the risk of not receiving full payment is accepted by the professional groups.

Supervisors anxious to see medical care plans developed in their counties should make studies of the medical care experience of the borrower families and present a request for assistance well documented with as specific material as possible concerning the clients' medical care needs. The establishment of medical care plans may be postponed indefinitely in a few counties with large urban centers, but there is no reason why such plans cannot be developed in the great majority of counties in Region I, and the interest expressed by the Supervisors is bound to carry weight with the State Director as he selects counties for the development of plans each fiscal year.

APPENDIX

Exhibit A - Typical Medical Care Plan

MEDICAL CARE PLAN FOR FARM SECURITY ADMINISTRATION CLIENTS IN _____ COUNTY,

I - Purpose

Through the collaboration of the _____ County Medical Society and the Farm Security Administration of the United States Department of Agriculture, to make available to low-income farm families in _____ County who are clients of the Farm Security Administration a medical service plan on a prepayment basis whereby these families may receive necessary medical care as an aid to their rehabilitation, and the physicians may be reimbursed for their services.

II - General Principles

A - County Medical Society supervision over all medical aspects of the plan.
B - Free choice of physician from among those participating.
C - Voluntary participation, on the part of both physicians and client families.
D - Family participation rates based on average incomes of clients in the area.
E - Annual family dues deposited in advance in the hands of a bonded Trustee who administers the "pooled" or common fund as a Trust Fund on behalf of the clients.

III - Organization

A - A Medical Review Committee composed of three physicians appointed by the President of the _____ County Medical Society, which reviews and audits monthly bills, brings to the attention of the County Supervisor of the Farm Security Administration matters affecting the clients, keeps the County Medical Society informed concerning the operation of the plan, and exercises general medical supervision over the plan.

B - The County Rehabilitation and Home Management Supervisors of the Farm Security Administration, who assist clients in financing their participation in the plan, clear problems of family or individual eligibility with the Medical Review Committee, educate the families as to their responsibilities under the plan, deal with instances of abuse of privilege by families upon request of the Medical Review Committee, and keep clients informed concerning the operation of the plan.

C - An Advisory Committee of Clients which keeps informed concerning the plan, interprets the families' viewpoint to the Supervisors, (and as desired to the Medical Review Committee), and assists in educating the families and in eliminating abuses.

D - A Trustee, who is not a member of one of the three interested groups (physicians, FSA representatives, client families), but whose selection is approved by the Medical Review Committee, the Farm Security Administration Supervisors, and the Advisory Committee of Clients; who, acting as the agent of the families, receives their dues; maintains a Trust Fund in a local bank; deducts $1.00 from each family's dues (total dues for all health services) for administrative expenses including bonding fee, ledgers, stationery, postage and payment for personal services; disburses funds in payment of physicians' bills in accordance with the plan; keeps suitable records of financial transactions and services rendered; and submits reports concerning the operation of the plan to the Medical Review Committee and the Farm Security Administration.

E - An Arbitration Committee to deal with any disputes which may arise, and to act on dropping a family from the plan for flagrant abuse; to be composed of two physicians from the Medical Review Committee, two clients from the Advisory Committee of Clients, and a fifth member selected by these four.

IV - Families Eligible to Participate

Only those farm families living in _____ County who are clients or borrowers of the Farm Security Administration, U. S. Department of Agriculture. Families to receive identification cards indicating eligibility for services for a given period, after their dues have been deposited with the Trustee.

V - Physicians Eligible to Participate

All legally qualified doctors of medicine who practice in _____ County, who are members of the _____ County Medical Society or of Medical Societies in adjacent Counties, or are eligible to be members of such Societies, and who signify their desire to provide medical care on behalf of participating families under this plan. A list of such physicians to be furnished the Farm Security Administration Supervisor by the County Medical Society. Participating families to have free choice of physicians from among those listed.

VI - Medical Services

A - General Practitioner Care

1 - Medical care in the office and home, such as is ordinarily rendered by a general practitioner of medicine, including obstetrical care (with pre- and post-natal care); the treatment of minor injuries and fractures not requiring hospitalization; and the provision of ordinary drugs and dressings such as the physician himself may be accustomed to dispense or employ in the office or home, but not including drugs furnished on prescription. In chronic cases, office or home calls will be limited to one a week, except for some acute exacerbation of the disease.

2 - Preventive services, including (a) annual health examination of any participant on a selective basis when the physician considers it advisable; (b) desirable immunizations and other prophylactic measures not available through the county or state public health program (the participant to pay the cost of materials not furnished free by any health department, and the physician to charge against the fund the regular office call fee agreed upon).

3 - Care of hospitalized medical and obstetrical cases, such as is ordinarily rendered by a general practitioner of medicine (limited to acute and emergency conditions such as pneumonia and serious obstetrical complications). 1/

4 - Minimum X-ray service necessary to establish diagnosis in traumatic cases, when service furnished by practicing physician or radiologist.

B - Surgical and Other Specialist Care of Hospitalized Cases

1 - Within the scope of this plan, surgical and other specialist care of hospitalized cases to be confined to acute and emergency conditions such as serious injuries including fractures requiring hospitalization; surgical emergencies such as appendicitis, intestinal obstruction, and mastoiditis; and obstetrical complications beyond the scope of general practitioner care. 1/

2 - Not included: Surgical treatment of conditions known to the participant to exist at the date of application for participation in the plan. 2/

VII - Annual Participation Rates and Payment of Dues

A - Annual Rates for Medical Services 3/

Size of Family	General practitioner care	Surgical and Specialist care	Administrative expense	Total
Single person	8.00	3.00	1.00	12.00
Family of 2	15.00	4.00	1.00	20.00
Family of 3	16.00	5.00	1.00	22.00
Family of 4	17.00	6.00	1.00	24.00
Family of 5	18.00	6.00	1.00	25.00
Family of 6 or more	19.00	6.00	1.00	26.00

1/ The limitation of care of hospitalized cases to acute and emergency conditions is required in the majority of plans because of the limited funds available.

2/ Such treatment, though not a proper charge against the fund, can often be financed separately by the family, with FSA assistance.

3/ Rates for hospital care are included in the Hospital Care Plan agreed upon by the local hospitals rather than in this agreement covering physicians' services.

B - Annual dues to be deposited with the Trustee in advance by the individual families.

C - An extra charge of $10.00 for obstetrical care to be deposited with the Trustee in advance.

D - The Farm Security Administration to assist clients in financing their participation, ordinarily through loans which must be repaid along with regular rehabilitation loans.

E - Definition of family eligibility: The family is defined as the husband and wife and all members of the family living in the same household and dependent upon the head of the house for support. 1/

VIII - Payment of Physicians' Bills

A - General Practitioner Care

1 - Family dues for general practitioner care, as listed in VII A, to constitute and be administered as a distinct fund.

2 - The general practitioner care fund to be divided into twelfths, with one-twelfth available for the payment of bills each month. 2/

3 - The attached fee schedule covering general practitioner services, agreed upon by the _____ County Medical Society, to be used as a basis for charges under this plan.

4 - Physicians to submit monthly bills for services to the Trustee, 3/ using a bill form approved for the purpose by the Medical Review Committee. Bills to be in the hands of the Trustee by the tenth day of each month for services rendered during the previous month. Bills received late to be reduced by one-third and added to the bills for the next month.

5 - The Medical Review Committee, having received assembled bills from the Trustee immediately after the tenth day of each month, to review and audit bills and submit them by the twentieth day of each month to the Trustee who will then pay approved bills as follows:

(a) Bills to be paid in full if the monthly allotment of funds is sufficient.

1/ Some plans include a statement such as the following: An elderly parent or othe family member receiving from any source more than $15.00 per month to be considered not dependent and, therefore, obliged to pay the single rate for participation if desired.

2/ Alternative arrangement: General practitioner care fund to be divided into unec monthly allotments, with larger allotments in the winter months, for example, 7% of fund allotted to each month from April through November, and 11% to each month from December through March.

3/ In some plans the bills are sent directly to the Chairman of the Medical Review Committee.

(b) If funds are insufficient to pay the bills in full, all available funds for the month to be distributed on a pro rata basis to physicians submitting bills.

(c) Payment for obstetrical care to be as follows: The physician to receive $10 of his fee without any reduction (the $10 extra which the family deposits in advance with the Trustee) and the remainder of his fee from the regular monthly allotment as provided in (a) and (b) above.

(d) Any surplus remaining after bills for a given month are paid, to be held over to the end of the plan's fiscal year, when any accumulated surplus will be applied on a pro rata basis against any unpaid balances still owed to physicians. 1/

(e) Any surplus remaining at the end of the plan's fiscal year, after all payments have been made as above, to be distributed over the twelve months of the next fiscal year, increasing the monthly allotments, or, in the event the plan be discontinued, to be returned to the clients on a pro rata basis, in proportion to their participation dues paid in during the year in which the surplus occurred.

(f) At the end of each fiscal year, after all available funds have been expended in the manner outlined above in the payment of physicians' bills, any outstanding balances due on physicians' accounts for services rendered under the plan to be written off as paid in full.

B - Surgical and Other Specialist Care of Hospitalized Cases

1 - Family dues for surgical and other specialist care, as listed in VII A, to constitute and be administered as a second distinct fund.

2 - The surgical and specialist care fund to be divided into four equal parts, each to be available for the payment of bills on a quarterly basis.

3 - A uniform fee schedule covering surgical and specialist services to be agreed upon by the _____ County Medical Society to serve as a basis for charges under this plan. 2/

1/- Alternative arrangements: (1) Distribution of any monthly surplus over remaining months of the fiscal year, increasing allotments for those months; (2) distribution of any monthly surplus over the allotments for the months December through March but only such of these months as fall within the current fiscal year, and if no such months remain in the fiscal year at the time when the monthly surplus occurs, the surplus to be held to the end of the fiscal year for distribution.

2/- Fees charged for surgical and other specialist care are ordinarily in line with fees paid by welfare and relief agencies, but this is a matter for the County Medical Society to decide.

4 - Bills for surgical and specialist care to be submitted to the Trustee by the tenth day of each month, to be forwarded by him to the Medical Review Committee with other bills. The Medical Review Committee to audit these bills, indicating for the benefit of the Trustee not only the amount approved for payment but also the fact that payment is to be made from the surgical and specialist care fund.

5 - The Trustee to hold approved bills for surgical and specialist care until the end of each quarter of the fiscal year, at which time the payment of these bills and the distribution of any surplus will be handled in the manner outlined in A 5 above except that such transactions will be on a quarterly rather than a monthly basis. The final settlement at the end of the year also to be similar to that outlined above.

IX - Control of Abuses on the Part of Participating Families

A - Participating families to be educated by Farm Security Administration personnel as to their responsibilities under the plan, it being emphasized that any patient must go to the physician's office rather than call the physician to the home, except when the condition of the patient warrants a home call, and that home calls must be requested during the day when at all possible rather than at night. Participating families to receive a simple and clear outline of the features of the plan in which they are interested.

B - Abuse of privileges on the part of the families to be brought by the physicians to the attention of the Medical Review Committee, which may bring such cases to the attention of the Farm Security Administration Supervisors. Such abuses to be handled by the Farm Security Administration Supervisors with the assistance of the Advisory Committee of Clients.

C - Any case of repeated abuse of privileges, continued despite warnings, to be taken up by the Arbitration Committee composed of two physicians from the Medical Review Committee, two clients from the Advisory Committee of Clients, and a fifth member selected by these four. Any such family to be given an opportunity to present its case to the Arbitration Committee prior to withdrawal of privileges, the power to effect which shall rest with this Committee. Any portion of the family's annual dues remaining in unexpended allotments of the funds to be refunded to a family dropped from the plan.

X - Keeping Cost of Drugs to a Minimum

The _____ County Medical Society agrees to urge the cooperation of physicians to the end that the cost of prescribed drugs to the families may be kept to a minimum. The specific recommendation is made that U. S. Pharmacopoeia and National Formulary drugs be prescribed whenever possible and that full advantage be taken of free sera, vaccines and other preventive or therapeutic agents furnished free through health departments.

XI - Obligations of Physicians under the Plan

A - A participating physician to be as free as in the rest of his practice to accept or reject a case; and to maintain all relationships between himself and these patients, including the confidential relationship, in accordance with the usual code of medical ethics.

B - If for any reason a physician is not in a position to render a certain service when called upon to do so by the client, it is expected that if necessary the physician will assist the client in securing the services of another physician who is a participant in the plan.

C - A physician may withdraw from participation in the plan by giving written notice of such intention to the Trustee. In that event, the physician will receive payment for services already rendered in the same manner and to the same extent that he would have received the same had he not withdrawn.

XII - Duration of Agreement

The agreement or understanding between the _____ County Medical Society and the Farm Security Administration, as outlined in this plan, is considered to be in effect for a one-year period without any major change, with continuation of the plan with or without modification to be subject to the mutual approval of all parties concerned.

Typical Fee Schedule for General Practitioner Care 1/

Office calls - $1.50
(Includes ordinary medicines and dressings dispensed or employed by the physician, and any one routine service such as a urinalysis, a haemoglobin determination, or an immunization procedure. Each additional service of this kind, including red cell counts, white cell counts, and white cell differentials - $0.50)

House Calls - 2.00
(Covering a two mile radius from office; mileage over two miles, 15¢ per mile both ways)

Night calls (requested between 10 P. M. and 7 A. M.) - - - - - - 3.00
(Same mileage charge as for house calls during day)

Hospital calls (by general practitioner in medical cases)
First call - 2.00
Subsequent calls - 1.50

Obstetrical cases - 25.00
(Including ordinary pre-natal and post-natal care)

Consultations
(Permitted at request of attending physician; the fee in ordinary cases to be the usual home call fee; in obstetrical cases, usual fee plus $5.00; fee for giving anesthetic in obstetrical case - home call fee plus $5.00)

Minor surgical procedures - - - - - - - - - - - - - - - - - 3.00 to 15.00
(Including fractures requiring minimum amount of care)

X-rays (for diagnosis only in traumatic cases) - - - - 2.50 to 5.00

Note: In unusual cases, including minor surgical and fracture work, and in acute medical cases requiring more than one home or hospital visit per day, the physician may set what he considers a fair fee in line with other fees and may describe in detail the emergency character of the case. The Medical Review Committee's decision regarding full or partial payment is to be accepted as final.

1/ The FSA does not set fee schedules. This sample schedule is in most respects typical of those adopted by medical societies in Region I to serve as a basis for charges for general practitioner care under these plans. As indicated in VIII B 3 above, no attempt is made to suggest a fee schedule for surgical and other specialist care, for there is considerable variation in such schedules adopted by medical societies. As a rule, the fees are in line with those paid by welfare and relief agencies.

HOSPITAL CARE PLAN FOR FARM SECURITY ADMINISTRATION CLIENTS IN _____ COUNTY, _____ 1/

I - Purpose and General Principles

The purpose and general principles underlying this plan of emergency hospitalization are analogous to those outlined in the attached "Medical Care Plan for Farm Security Administration Clients in _____ County, _____." The specific purpose is to provide limited emergency hospitalization as a necessary part of the general plan of providing health services for client families in this county. The clients are to have free choice of hospital from among those hospitals in _____ County and in adjacent counties which agree to extend services under this plan.

II - Families Eligible and Loans for Participation

Clients of the Farm Security Administration in _____ County, assisted by loans when necessary, to pay in advance into a Trust Fund the sum of $10.00 per family ($6.00 - single rate) for emergency hospitalization for a one-year period, in addition to contributions for medical services in accordance with the attached Medical Care Plan. The members of a family eligible to participate as a family unit include the husband and wife and all members of the family living in the same household and dependent upon the head of the house for support.

III - Trustee and Hospitalization Fund

The Trustee, selected to serve as the agent of the clients, to administer the Hospitalization Fund as well as the General Practitioner Care and the Surgical and Other Specialist Care Funds. The Trustee to deduct $1.00 from each family's dues (total dues for all health services) for administrative expenses; to disperse funds in payment of hospital bills in accordance with the plan; to keep suitable records of the financial transactions and hospital services rendered; and to submit reports concerning the operation of the hospital plan to the hospitals concerned and the Farm Security Administration.

IV - Services

A - Limitations and Exceptions

1 - The following services shall be available to the participants only in urgent, acute, and emergency situations such as injuries, fractures requiring hospitalization, acute abdominal surgical conditions, acute medical cases in urgent need of hospital care, and complicated obstetrical cases where home care would endanger

---

1/ This typical Hospital Care Plan should be considered part of the general medical care plan, but it is presented here as a distinct document because ordinarily such a plan constitutes a separate agreement with the hospitals. This particular sample plan is almost identical to one operating since July 1, 1940, in New York State.

the patient. Hospital services will not include the treatment of conditions known to the participant to exist and to require hospital care at the date of application (except for complicated obstetrical cases within the limitations outlined). Elective surgical cases including tonsillectomies will not be included. Services cannot be provided for pulmonary tuberculosis, venereal diseases, mental disorders, and quarantinable diseases (unless regularly accepted by the hospital concerned.)

2 - Hospital care shall include the care of obstetrical cases (any condition arising from pregnancy), only upon written certification by the attending physician that hospital care is urgently required and that home care would endanger the patient. Such care shall include the ordinary nursing care of the newborn child for the duration of the hospital stay of the mother, provided the hospital care shall not exceed 14 days.

3 - No patient shall be admitted to a hospital except when such case has been referred by a physician, unless the services of an outside physician are not immediately obtainable (in an emergency case.) As soon as any patient receiving hospital care has been discharged from the hospital such patient shall be referred back to the physician who sent him to the hospital for any after-treatment that is required.

B - Outline of Services

1 - Hospital care for 14 days (per person, in one or more admissions, with a limit of 28 days per family).

2 - Bed and board in ward accommodations.

3 - General nursing care (special nurses not included).

4 - Use of operating room.

5 - Use of delivery room (subject to limitations set forth above).

6 - Ordinary medications and dressings. (This excludes special prescriptions and sera).

7 - Routine laboratory examinations, consisting of (1) urinalyses, (2) blood counts, (3) stool examinations, (4) examination of pathological tissue.

8 - Special diagnostic or therapeutic procedures such as X-rays, basal metabolism tests, and oxygen therapy, but only up to a total cost of $10.00 at ward rates in any one case.

V - Management of Hospitalization Fund and Payment of Bills

A - The Trustee will divide the Hospitalization Fund into four equal quarterly allotments.

B - A uniform schedule of hospital charges will be agreed upon by the hospitals in _____ County to serve as a basis for charges under this special plan.

C - Hospital bills will be submitted to the Trustee on a monthly basis by the tenth day of the month following the month in which services were rendered. In an obstetrical case the hospital must submit to the Trustee the physician's signed statement that hospital care was considered essential.

D - The Trustee is privileged to request the Medical Review Committee, or a member of the Committee, to review hospital bills each month in view of his lack of familiarity with professional terms, a knowledge of which is sometimes essential to proper interpretation and evaluation of bills from the point of view of eligibility for payment under the plan.

E - Hospital bills for services covered in the understanding will be paid by the Trustee. The patient will be responsible for the payment of any costs over and above those covered by the understanding.

F - If the quarterly allotment of funds is sufficient all hospital bills received for the quarter will be paid in full.

G - If the quarterly allotment is insufficient to pay the bills in full it will be applied against the hospital bills on a pro rata basis.

H - If there is a surplus after bills for a given quarter are paid, it will be distributed in equal sums among the remaining quarters of the plan's fiscal year, increasing the allotments for those quarters.

I - Surplus funds remaining after payment of bills for the fourth quarter shall be applied against unpaid balances which may still be owing on bills received during the year. If any surplus remains after payment of all bills in full, it shall be carried over in the Hospitalization Fund to be added in equal sums to the quarterly allotments for the following year, or, if the plan be discontinued, such surplus shall be distributed to clients on a pro rata basis in proportion to the original amounts paid in by them for hospitalization.

J - It is understood that at the conclusion of a twelve-month period, after all payments have been made as above, the bills will be written off as paid in full.

VI - Safeguards

Both physicians and participating families will be informed fully and in specific terms regarding the benefits provided under this agreement, with a view to restricting the demands for services rigidly, in accordance with the provisions of the plan outlined above.

VII - Duration of Agreement

The agreement or understanding between the hospitals listed below and the Farm Security Administration, as outlined in this plan, is considered to be in effect for a one-year period without any major change with continuation of the plan with or without modification to be subject to the mutual approval of all parties concerned.

Typical Schedule of Charges for Hospital Ward Care 1/

Daily charge for ward care (Including bed and board, general nursing care, and ordinary drugs and dressings)	$3.00
Use of operating room	5.00
Use of delivery room	5.00
Anesthesia	5.00
Routine laboratory fee	3.00
Daily charge for care of newborn infant (Limit of 14 days)	0.50

X-rays, basal metabolism, etc. - usual ward rates.

1/ This sample schedule is the one employed in the hospital care plan referred to in the note at the bottom of page 9 of this Exhibit.

Exhibit B - Abstract of Typical Plan for Distribution to Clients

MEDICAL CARE PLAN FOR FARM SECURITY ADMINISTRATION BORROWER FAMILIES

IN _____ COUNTY, _____

I - Purpose of the Plan

This plan has been developed through the cooperation of the physicians and hospitals in this County. It is designed especially for families taking loans from the Farm Security Administration, and its purpose is to assure them necessary medical and hospital care at a cost which they can budget and pay in advance. Participation is voluntary.

II - How the Plan Operates

A - Families deposit their year's dues in advance with Mr. _____ of _____ who has agreed to serve as Trustee of the special medical care fund. This fund is built up from contributions of all families joining the plan. When families get medical or hospital care, the bills are sent to the Trustee instead of to the families, and they are paid throughout the year from the special fund.

B - Each family receives a Participation Card from the Trustee on which are listed all members of the family entitled to services. Family membership includes husband and wife and all members of the family living in the same household and dependent on the head of the family for support. As a rule, married children must take out their own membership.

C - Families are free to select their family physician, surgeon, and hospital from among those taking part in the plan.

III - Services Included in the Plan

A - General Medical Care (Family Physician Care)

1 - Visits to the doctor's office.
2 - Home calls made by your doctor.
3 - Care in confinement cases, including pre-natal care, delivery, and post-natal care.
4 - Treatment of minor injuries and fractures.
5 - X-rays necessary to establish the diagnosis in fracture or suspected fracture cases.
6 - Ordinary medicines and dressings. (Drugs furnished by a druggist on prescription and unusual or expensive drugs not included.)
7 - Desirable preventive measures such as vaccinations if they are not available through any public health department. In such cases the families must pay the cost of vaccines or other material not furnished free through the health department, but there is no charge to the family for the doctor's services.

8 - Annual physical examination of any member of the family, when the physician considers it advisable.
9 - In chronic cases, office or home calls will be limited to one a week except when the chronic condition becomes acute.

B - Care of Hospitalized Cases

1 - Types of Cases Entitled to Hospital Care Under the Plan

The services listed below are available to the families only in acute and emergency cases such as serious injuries, fractures requiring hospitalization, surgical emergencies such as appendicitis or mastoiditis, acute illnesses such as pneumonia, and complicated confinement cases in which hospital care is urgently required and home care would endanger the patient. These services do not include the treatment of conditions known to the participant to exist and to require such treatment at the date of application for participation in the plan. Services cannot be provided for tuberculosis, venereal diseases, mental disorders and contagious diseases which are quarantined (unless such cases are regularly accepted by the hospital concerned).

2 - Physicians' and Surgeons' Care of Hospitalized Cases

Within the limitations outlined above, the families are entitled to care in hospital rendered by their family physician or by a surgeon or other specialist of their choosing.

3 - Hospital Services Under the Plan

Hospital care for 14 days (per person, in one or more admissions, with a limit of 28 days per family during the year).
Bed and board in ward accommodations.
General nursing care (special nurses not included).
Use of operating or delivery room.
Ordinary drugs and dressings (not including special prescriptions, special serum, etc.).
Routine laboratory examinations.
Special procedures for diagnosis or treatment such as x-rays, basal metabolism tests, and oxygen, but only up to a total cost of $10.00 at ward rates in any one case.

IV - Annual Participation Rates

Single person - - - - -	$18.00	Family of 4 - - - - - - -	$34.00
Family of 2 - - - - - -	30.00	Family of 5 - - - - - - -	35.00
Family of 3 - - - - - -	32.00	Family of 6 or more - - -	36.00

Extra charge for confinement case - - - - - $10.00

V - How to Get Medical and Hospital Care Under This Plan

A - Any patient requiring medical care must go to the physician's office rather than have the physician call at the home, except when the condition of the patient warrants a home call.

B - Home calls must be requested during the day when possible rather than at night.

C - That patient should show the physician the family Participation Card so that he will send the bill to the Trustee for payment. If the physician does not know about the plan, he should be told to get in touch with the Trustee, the Medical Society, or the FSA Office, for complete information concerning the operation of the plan.

D - No patient should go directly to a hospital or a surgeon, but should be referred to them by his family physician except in case of emergency. If hospital or surgical care is required, it is wise to determine at the outset whether the service is covered by the plan. If it is not covered, the hospital or the surgeon as well as the family should understand that the family is itself responsible for meeting the cost of the care in some other manner than through the plan.

VI - Abuse of Privileges

A - It is expected that every family will use good judgment in the matter of obtaining medical services. Abuse of the plan by one family will affect the group as a whole. If one family takes unfair advantage of the plan, it leaves that much less money available to take care of what may be a "life and death" case with another family. Every family is counted on to "play fair".

B - If in spite of warnings a family continues to abuse its privileges, and if the continued participation of the family appears to be endangering the success of the plan, such a family may be dropped from the plan by action of an Arbitration Committee composed of two members of the Advisory Committee of Clients, two physicians, and a fifth person whom they may select. The family will be given a hearing before the Arbitration Committee if it so desires. If the family is dropped, any unexpended dues are refunded.

VII - Advisory Committee of Clients

An Advisory Committee of three or five clients will represent the borrower families in all matters affecting the plan. This Committee aids in selecting a Trustee. It is responsible for keeping informed concerning the operation of the plan, and for suggesting possible improvements. The Committee also reviews complaints concerning abuse of privileges and helps to determine ways and means of handling such cases. The Committee is given an opportunity to take an active interest in all phases of health work.

Exhibit C - Participation Agreement

1. I hereby agree to participate in the _____ County Medical Care Plan on behalf of my family, for a period of _____ months beginning _____, 194_, and agree to deposit with _____, Trustee, the sum of _____ dollars ($____), for health services. If there is a confinement case in my family I agree to deposit an extra $_____ with the Trustee in advance or during the month in which the confinement takes place.

2. My deposit shall be pooled by the Trustee with those paid by others to make up the Trust Fund, and this Fund shall be maintained as such in the _____ _____ Bank of _____. Not more than 5% of the Trust Fund may be used by the Trustee for a bond premium and other administrative expenses. The remainder of the Trust Fund shall be used to secure for me and other persons participating in this plan necessary medical and other health services as specified below. Any surplus at the end of the year shall be carried over in the Trust Fund to the succeeding year, or, in the event the plan be discontinued, the surplus shall be distributed to me and other participants in proportion to our participation amounts paid in.

3. The services I may expect are outlined in the attached Abstract of the _____ County Medical Care Plan, a complete copy of which Plan is on file in the FSA Office in _____. The Trustee shall not be responsible for the performance of the agreements on which the Plan is based but will use his best efforts to secure necessary services for me if there should be any difficulties under any of these agreements. The Trustee is simply to handle the Trust Fund in accordance with this agreement.

4. The State Director of the FSA for this State, at the time in office, shall have the power to remove the Trustee named herein when, in his judgment, the Trustee is not performing his duties properly. Upon such removal, the State Director shall become the Trustee. The Trustee named above shall give a faithful performance bond satisfactory to the State Director, to secure performance of his duties. The bond shall be in favor of the said State Director who may act for me in all matters involving the bond, and who shall use any amounts recovered for the purposes of this Plan.

5. I agree to do my share in the health program by following the advice of my physician and the public health department, carrying out the food production and preservation program in my FSA Farm and Home Plan, keeping my home and outbuildings clean, free of insects, and screened properly, and keeping my well or other drinking supply free of contamination.

Names and ages of all other members of my family living in my home and dependent upon me:

	Name	Age
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

(List other names on back)

1. _____
Participant

_____
Address

_____
Date

Family doctor _____
His address _____

I accept this application and the responsibilities of Trustee under this agreement.

_____
Trustee

Exhibit D - Identification Card

The identification cards can be printed at very low cost by a local printer. A sufficient quantity can be made up at one time to last for several plan years, at no great increase in expense. This card should be made up on durable material, about 180 pound ledger stock, and should be about 2-1/4" by 3-3/4" in size.

Farm Security Administration
_____ COUNTY MEDICAL CARE PLAN

P A R T I C I P A T I O N C A R D

No. _____

Name _____

Address _____

and the members of the family listed on the back of this card are eligible for services under this plan for the period beginning _____ and ending _____.

_____
Trustee

On the back of the identification card should be typed a list of those members of the family eligible to participate. This list should correspond with that on the member's ledger sheet in the Trustee's records.

Form FSA-RR 23
(9-1-37)

UNITED STATES DEPARTMENT OF AGRICULTURE
FARM SECURITY ADMINISTRATION

Exhibit E

(Service number)

(Case number)

COMMUNITY AND COOPERATIVE SERVICES APPLICATION

1. Name of service Mercy County Medical Care Plan

Borrower or borrowers Clients listed below
(Where there are two or more owners of the service, attach partnership agreement)

P. O. Mercy County Mercy State Transylvania

2. (*a*) Amount of loan requested, $ 2076.00 (*b*) Local capital furnished, $ $136.00 cash 361.00 grants

(*c*) Total cost of service, $ 2573.00 (*a* plus *b*) (*d*) Purpose of loan ~~To provide~~ (List items to be purchased)
medical and hospital services for client families

3. Justification: How will this service strengthen the farm plan(s) of the clients and aid in rehabilitation? (Attach concise statement.)

4. Annual income (estimated): (Participation agreements attached.)

NAMES OF USERS	Borrower(s) amount of this loan	Status: C—Client L—Low income O—Other	No. of persons ~~Number of units~~ to be serviced XXXXXXX eligible	Service fee per unit	Amount to be paid by participants
Appleseed, John	$ 32.00	C	3	$	$
Ballie, William		C	4		34.00-grant
Clump, Christopher	20.00	C	7		16.00-grant
Dodge, Fred C.	34.00	C	4		
Evergreen, Joe		C	3		32.00-cash
Etc.					
Five copies of this Form FSA-RR 23 to be made up and one copy of each of the following to be attached to each FSA-RR 23 prepared:					
Narrative statement indicating date plan was adopted by County Medical Society and date plan placed in operation.					
Copy of Medical Care Plan.					
Copy of Participation Agreement.					
Distribution:					
One copy to County Office file.					
One copy to State Office.					
Three copies to Regional Office.					

XXXXNOTE.—When this space is inadequate to list all participants, use for summary only XXXXX and attach separate sheet giving required information.
Additional information required.

Total estimated income $

Summary of participants: C. 74 L. O. Total participants 74 (384 persons

8-1007

5. Annual expense: (Estimated for typical year. Do not include repayment of loan as expense.)

(a) ~~Interest~~	$	(g)	$
(b) ~~Taxes~~		(h)	
(c) ~~Insurance~~		(i)	
(d) ~~Feed—repairs~~		(j)	
(e) ~~Vet.—grease—oil~~		(k)	

(f) ~~Manager's~~ Trustee's allowance $1.00 per family.

Total of annual operating expense $ 74.00

6. Financial summary:

Total income (from item 4)	$	Annual repayment on this loan	$
Total expense (from item 5)		Amount of balance after all payments are made. (Add this item to Table (P) of farm plan.)	
Net income (estimated)			

7. (a) Repayment schedule: (Arrange to have repayments made at time fees are collected for services.)

(b) Security:

8. Recommendations for the approval of the application in the amount of $_____ to be loaned to individual borrowers by the Farm Security Administration for the establishment, operation, and/or maintenance of the community and cooperative services being petitioned. Secure County Agricultural Agent's approval of application or a letter of endorsement from him.

January 2, 1941 (Date)	John Doe (County R. R. supervisor)
~~January 8, 1941~~ (Date)	Richard Roe (District R. R. supervisor or State director)
(Date)	(Regional cooperative section)
(Date)	(Assistant regional director in charge of rehabilitation)

Approved by: _____

_____

U. S. GOVERNMENT PRINTING OFFICE 8—11097

Fiscal Year Ends December 31, 1940, Type Plan pool

UNITED STATES DEPARTMENT OF AGRICULTURE
FARM SECURITY ADMINISTRATION

REPORT ON HEALTH SERVICES

Name of Group Jones Co. Medical Care Plan

Address Jonesville, Maine

Month of June, 1940

This report covers: dr and hospital and surgery accounts for three ~~Six~~ Month Period from April, 1940, to June, 1940

Territory Served Jones County, Maine

SECTION I	Total (1)	FSA Clients (2)	Nonclients (3)
1. Total number of FSA clients in territory served	140		
2. Number of member families beginning of reporting period	125	125	
3. Plus: Number of member families added this reporting period	2	2	
4. Less: Number of member families dropped this reporting period	—	—	
5. Number of member families at end of this reporting period	127	RR 127 RP	
6. Number of persons in member families end of this reporting period	567	567	

7. Annual membership fee scale is Single person - $18.00; family of 2 - $30.00; Fam. of 3 - $32.00; 4 - $34.00; 5 - $35.00; 6 or more 36.00.

Extra charges $10.00 for each obstetrical case

SECTION II A - Physicians' and hospital services.

No. of office calls 89 No. of home visits 29

No. of hospital calls 7 No. of Obstetrical cases 2 (by general practitioner)

Total days in hospital for hospitalized cases 71

NOTICE

Prepare two reports as of the close of business, June 30. One for the month of June and one for the past six-month period. This same procedure will be followed as of the close of business, December 31.

SECTION II B	Cash Balance at Beginning of Reporting Period (1)	Cash Received During This Period: Percent allocated (2)	Cash Received During This Period: Amount (3)	Number of Persons Served (4)	Number of New Cases of Illness This Period (5)	Funds Allotted to This Period (6)	Bills This Period: Amount Incurred (7)	Bills This Period: Amount of Scale-down (8)	Bills Still Unpaid (9)	Amount Paid This Period (10)	Cash Balance at Close of Reporting Period (11)	% Paid
1. Physicians	$ 1261.17		$ 21.00	42	27	$ 183.16	$ 257.60	$ 74.52	$ —	$ 183.08	$ 1099.09	71
2. Surgeons - Specialists	538.50		7.00	7	7	180.50	235.00	54.52	—	180.48	365.02	76
3. Hospitals	1005.50		11.66	8	8	336.82	296.00	—	—	296.00	721.16	100
4. Drugs												
5. Dentists	(Bills for hospital and surgical care are paid quarterly in this plan)											
6. Nurses												
7. Obstetrical Extra Chgs.	40.00						20.00			20.00	20.00	
8. Administrative	63.00		1.16				7.75			7.75	56.41	
9. Less Duplications in column 4				(13)								
10. Totals	$ 2908.17	100%	$ 40.82	44		$	$ 816.35	$ 129.04	$	$ 687.31	$ 2261.68	

EXHIBIT F

Signed John Doe (Name) Trustee (Title) July 22, 1940 (Date)

Form FSA 204
Rev. 8-8-40

(See detailed instructions on the reverse side)

INSTRUCTIONS FOR THE PREPARATION AND SUBMISSION OF THIS REPORT

GENERAL - This Report will be prepared by the trustee or person who keeps the accounts of the medical care association or group from information in the accounts which should be maintained substantially in accordance with procedure described in the "Simplified Accounting System for Medical Care Groups". The Report will be prepared in an original and four copies to be distributed as follows: Original and first copy to the regional director, attention of the specialist in Health Services; second copy to the state director; third copy to the county RR supervisor or community manager (a copy to each one when TP and/or RR and RP clients are members of the group); and the fourth copy retained by the medical care group.

HEADING - "Fiscal year ends" - Enter the date shown in bylaws or if the group is not formally organized, use date on which majority of memberships expire. "Type plan" - Pool, individual, or capitation. "This Report covers" - Fill in "Month of _____, 19___" if it is a monthly Report or "Six-month period from _____, 19____ to _____, 19___" if it is a semiannual Report.

"Name of group" - Enter the name by which the group or organization is known. "Address" - Mailing address.

"Territory served" - Enter the name of county or counties or other clear description of territory served.

SECTION I - Line 1, "Total number of FSA clients in territory served" - Insert the number of FSA client families eligible for membership in this medical care group. This information can be obtained from the county supervisor.

Line 5, "Number of member families at end of reporting period" - Include all families having a membership. When entering in column (2) the number of FSA client families at end of this reporting period, it is desired that the number of rehabilitation (RR) families and farm tenant (TP) families be shown in the upper half of the space provided and the number of project (RP) families (if any) be shown in the lower half of the space. In the space below (on line 6) showing number of persons, this division need not be made.

Line 7, "Annual membership fee scale is" - Give basis for calculating amount of fee each member family is to pay. For individual type plans, show range of amounts paid in per family. List any extra charges which the rules of the group require for special services such as physician's service on an obstetrical case.

SECTIONS II A and II B - The record of services given in this section will include all the services rendered during the reporting period. It will be prepared at some time during the month following the reporting period it covers when all bills for service during that reporting period have been submitted, reviewed, and bills, approved for payment, have been paid.

"Physicians' and hospital services" - Secure this information from physicians' and hospital statements covering totals of charges entered for physicians' and hospital services in column (7).

Column (1), "Cash Balance at Beginning of Reporting Period" - Obtain the cash balance from column (11) of the prior period's Report.

Columns (2) and (3), "Cash Received During This Period" - Include the receipts from members or others during the month or six-month period covered by this Report, as shown in the Cash Receipts Journal. The total amount received will be shown on line 10 with the distribution of the funds provided by the rules of the group for different types of service shown on lines 1 to 8. If there is no set percentage basis for distribution of fees, only the total on line 10, column (3), need be shown. However, entries in columns (4), (5), (7), (8), (9), and (10) will always show detail for each type of service involved even when the entry in column (3) and the entries in columns (1), (6), and (11) show totals only.

Column (4), "Number of Persons Served" - Enter the number of persons for whom physicians, hospitals, etc., have presented accounts covering service during this period. A count of the number of bills covered by the entries in column (7) will usually give this information though one bill may sometimes cover service to several persons. Deduction of the number of persons receiving more than one kind of service will be made on line 9 so that the entry on line 10 will show the number of different persons who received service of any kind from the association during this period.

Column (5), "Number of New Cases of Illness This Period" - Enter only those cases of illness, under each type of service, which began to receive that type of service during the period covered by this Report. The entries in column (4) included a certain number of cases of illness which began last period and for which the physician, hospital, etc. submitted bills for services last period. The entries to be made in column (5) must include only the cases of illness which began to receive physicians', hospital, or other type of service during the period covered by this report and must omit all cases which received that same type of service during the previous period. On the statement of account forms, recommended in the "Simplified Accounting System for Medical Care Groups", physicians and hospitals are asked to answer "Yes" or "No" to the assertion "This is my first statement for service to this case of illness". "Yes" entered here indicates a new case of illness. A new case of illness may also be discovered by noting on the membership ledger whether or not the person received this type of service during last period. In this column each type of service must be considered separately. A case may be an old case under physician's service if such services were received last period but a new case for hospital service if it entered the hospital during the period covered by this Report.

Column (6), "Funds Allotted to This Period" - Enter the funds available for the payment of this period's bills. If a certain portion of the funds is allotted for each type of service, show this division by entries on the proper lines. If there is no percentage division of funds in advance, show the total on line 10 only.

Columns (7) and (8), "Bills This Period"

"Amount Incurred" - Show total of bills for each type of service rendered during this reporting period, which has been tentatively or finally approved for payment by the reviewing committee.

"Amount of Scale-down" - Reflect the amount of reduction of bills from physicians, hospitals, and so forth, which was necessitated because of insufficient funds available during the reporting period.

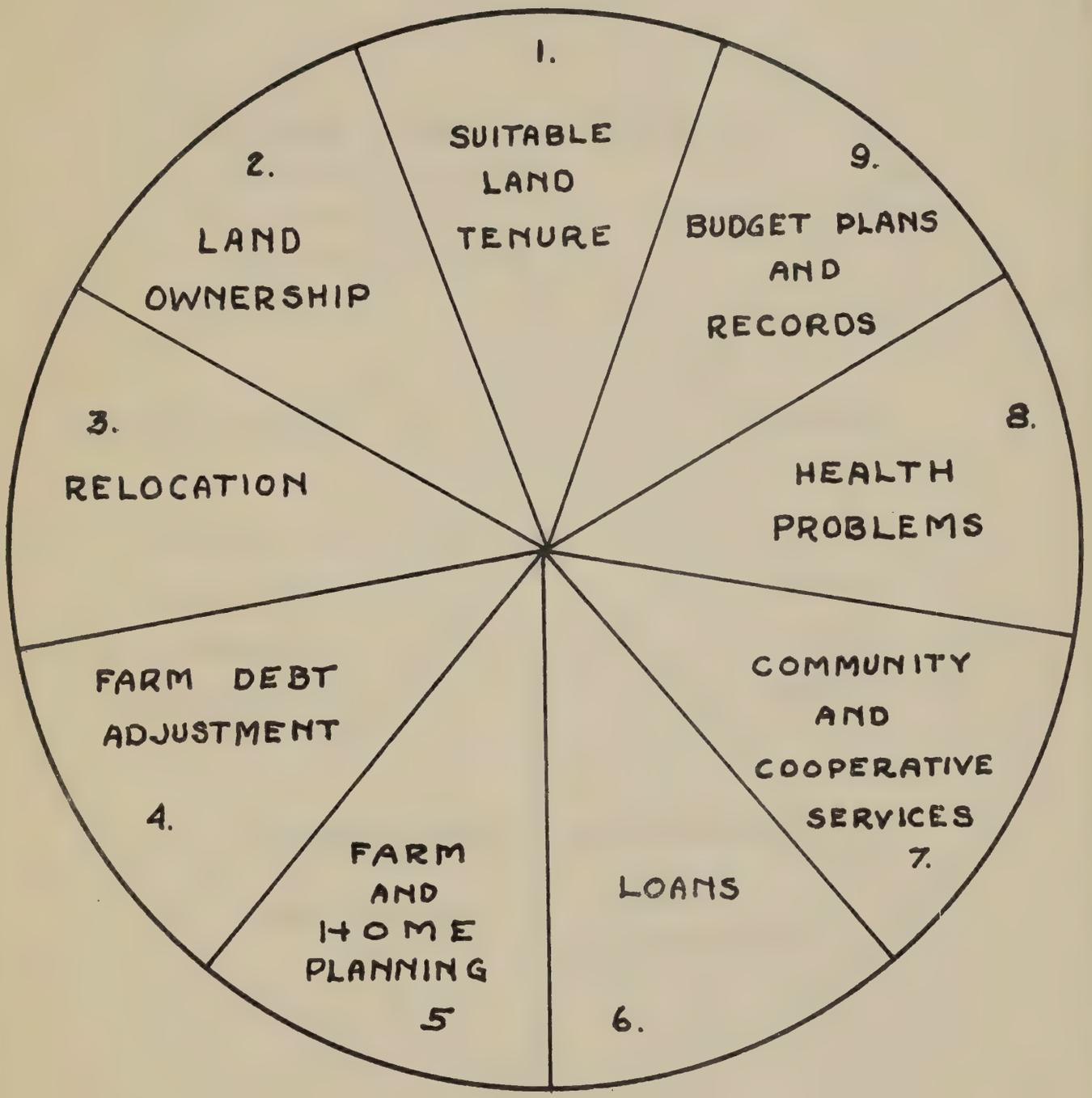
Column (9), "Bills Still Unpaid" - Show the total of all bills, payment of which has been delayed because the reviewing committee is holding them for further information or because of some other reason. This total should show the amount which will likely be paid on these bills after reductions due to scale-down have been made. It also should include all bills still unpaid regardless of whether or not the service was rendered during this reporting period.

Column (10), "Amount Paid This Period" - Enter the amount paid on bills incurred during this reporting period plus the amount paid during this reporting period on any old bills of previous periods.

Column (11), "Cash Balance at Close of Reporting Period" - Determine the entry for column (11), by obtaining the sum of columns (1) and (3) and subtracting from that sum the amount shown in column (10).

Exhibit G

MAJOR FACTORS IN THE REHABILITATION OF FARM FAMILIES



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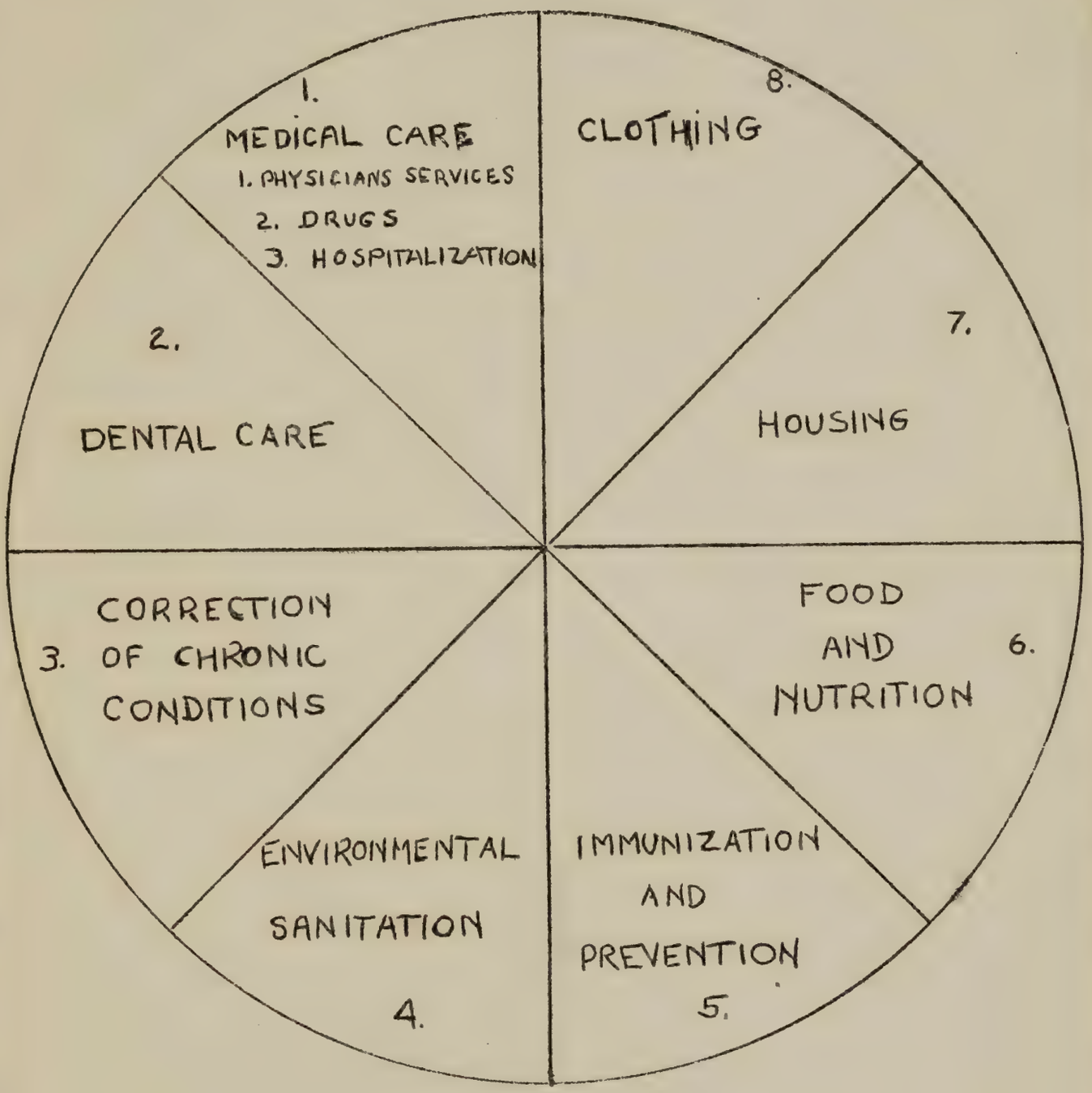
FARM SECURITY ADMINISTRATION

MAJOR FACTORS OF THE HEALTH PROGRAM IN THE REHABILITATION OF FARM FAMILIES



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FARM SECURITY ADMINISTRATION